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ABSTRACT

This guide for crisis debriefing teams (CDTs) in the Aurora public schools (APS) in Colorado is intended to provide immediate guidelines for schools to access trained support to deal with crises (such as serious injury or death) that can affect school communities. It is intended for use by counselors, psychologists, nurses, social workers, and community liaison workers trained to provide support to individual school building crisis teams. Individual sections of the guide provide the following: a summary of APS crisis debriefing team procedures, a procedural flowchart, a CDT manager's checklist, a list of teams, a crisis intake form, and guidelines for debriefing. Attached handouts provide information on: critical incident stress reactions, children's response to trauma, coping with children's reactions to trauma, myths and facts about suicide, "do's and don'ts" related to suicidal threats, responding to a student's death, ways parents can help, family grief, and helping children in the home. Also attached are a sample statement for initial announcement of a crisis event, a list of community resources, a form for recording students receiving counseling support, and a sample debriefing summary sheet. (DB)

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Aurora Public Schools

CRISIS DEBRIEFING TEAMS'

MANAGER'S HANDBOOK

FOR SERVICES OR INFORMATION

CALL:

340-0510
ext. 0

EC 305 763

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The information and procedures described in this handbook are intended to be used by trained personnel as guidelines in providing crisis debriefing for the Aurora Public Schools Communities. It should be noted that the most important element in the success of a debriefing is the specific training of the Team members.

CRISIS DEBRIEFING TEAMS'
MANAGER'S HANDBOOK

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APS CRISIS DEBRIEFING TEAMS' PROCEDURES

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APS CRISIS DEBRIEFING TEAMS PROCEDURES

The organizational and procedural guidelines for dealing with in-district crises was formulated by the CDT Committee during the 1994-1995 school year and was accepted by the District Administrative Staff in March of 1995. The plan is based on the training that was provided to support staff by the district in April of 1994 and March of 1995, research on debriefing plans from other school districts, and ongoing feedback from crises already experienced in APS over the past several years.

The purpose of the plan is to provide immediate guidelines for schools to access the trained support needed to deal with the emotional and psychological effects of crises that can effect school communities.

For the purposes of this plan, a **crisis** is defined as:

A sudden, generally unanticipated event that profoundly and negatively affects a significant segment of the school population and often involves serious injury or death.

Such events include the death or serious injury of a student or a staff member (accidents, homicides, suicides or attempted suicides), riots in or around the sites, kidnappings, rapes, and other events that may be viewed by the site personnel as crises.

Crisis **debriefing** is <u>not</u> the initial, first line or reactive response to a crisis but <u>is</u> rather the second line or proactive response aimed at helping individuals work through the effects of the trauma and return to affective emotional and behavioral functioning.

Approximately forty-five APS staff members from the positions of counselors, psychologists, nurses, social workers, and community liaison workers participated in the crisis debriefing workshops and volunteered to be on the district Crisis Debriefing Teams. The members have been grouped into four teams which are stratified on position, sex, level served (primary or secondary), and schedule (regular or year round).

Each team has two designated managers who will be the first members contacted when a request for the team is received. The managers will then contact the individual members of their team. The four teams will rotate as being the first team of debriefers called to a crisis. More members from each successive team can be called in when the need is known. In terms of having enough debriefers called in to handle the particular immediate and follow up needs of a situation, <u>it is recommended that we always err on having too many people available rather than not enough.</u>

The distinction needs to be clarified between the APS Crisis Debriefing Teams and the individual building crisis teams. Within each building, the principal and his/her support personnel constitute the building crisis team. The support personnel can include the assistant principal(s), counselor(s), social worker, psychologist, community

liaison worker, nurse, and other staff that are included on an individual building basis. The CDT committee has compiled a list, by each Aurora school and site, of the building crisis team members, which is included in the Handbook.

When a principal, with the collaboration of the building crisis team, decides that a need exists to bring in a district support team, the principal or his/her designee will call the Centretech Special Education office **(340-0510)** to start the process. The special education staff will check the records of CDT interventions and will pick the Team that is up next to contact first . The managers of the first contacted team will be the designated managers of that crisis debriefing situation. Those managers, in collaboration with the principal, his/her designees, and the members of the building crisis team, will help organize and manage the activities of the debriefing team.

If a need for debriefing support is made when Centretech is not open or if it is known that there will be a need the following morning, the call can be made to the director of the debriefing program, Dr. Everett E. McDowell (985-9866), or to members of the special education administration, who can begin the process by calling appropriate team managers and helping to plan for the debriefing needs of the situation.

The co-managers, in collaboration with their debriefing team members, the building's administrators and the building crisis team,will help determine what other resources are needed to be called in. To enlist needed outside and community resources, the crisis committee will maintain an updated outside resource list to be available in every building. Handouts that give helpful information and suggestions for dealing with different crises situations are also important, and the committee is working on a library of such handouts to be available from the team members and from the special education office. The library will also include books, articles, audio-visual aids, etc.

The principal and his/her support staff need to be responsible for having the necessary accommodations to support the debriefing team members. These include such things as:

1) appropriate space and time for debriefers to work with individuals and groups in privacy,
2) access to an adequate number of phones,
3) any helpful printed information such as staff lists, room numbers, maps of the building, etc.
4) provisions for meals, coffee, tea, etc.,
5) substitutes to facilitate release of teachers who are involved in the debriefing process. Feedback suggests that when large numbers of students and staff are involved, this is a necessity if the process is to be effective and the disruption of the normal school routine is to be minimized.

It is recommended that each school make these prearrangements as part of their building emergency plans.

Members of the district debriefing team can be involved in the following support actions:

1) help in the decisions regarding how the crisis information is given to students, staff, parents and the community (letters, forms and checklists will be available);
2) debriefings with individuals and groups of students and staff (allowing and helping staff and students to understand and work through their emotions concerning the crisis and to return to adaptive and functional emotional and behavioral levels);
3) accessing other resources from the community;
4) advising the principal on matters concerning mental health and the debriefing process;
5) providing short and long term support as needed.

The co-managers, in collaboration with the debriefing and building team members, will help determine what further actions are needed to effectively monitor the aftereffects of the crisis, such as the need for and amount of continued debriefing support over the following days. The use of effective debriefing strategies also includes evaluation of the circles of impact from the crisis. This refers to the process of identifying all individuals who are impacted by the crisis, from those at the crisis site to anyone connected with those individuals who might experience trauma from the crisis. An example from our experience with debriefing in one building, following the death of a student who committed suicide, is the need to contact and provide debriefing for friends and past classmates who are impacted in other buildings.

Efforts should be made to provide debriefing for those students and staff who were not in attendance in the crisis building on the day initial debriefing began. Daily effort needs to be made for a few days on a regular basis to monitor for those individuals who have not had the opportunities for debriefing.

Since the school community, even on a district wide basis, is a close one with its own always surprising grapevine, it is recommended that the whole school district community be informed when anyone, student or staff, dies or is seriously injured. It is also recommended that when giving information about a crisis to anyone, students or staff, the truth as it is known at the time, should always be told.

Office support staff such as the secretaries are in high stress positions for long hours during a crisis. They need immediate support in terms of information that is appropriate to tell callers and the many people that will probably walk through their doors. They need to know what to tell the media and where to direct them. They need to know what resources are available to callers who ask and when it is appropriate to give out. They need support and breaks in dealing with the stress.

It is recognized that each building is unique in many ways and may want to adapt the debriefing process to fit their uniqueness. **The process of debriefing is a dynamic one and requires flexibility.** The debriefing needs of a site will differ

depending on such variables as sizes of student and staff populations, number of assigned support personnel, and whether the support people have CDT training or not.

The committee, with feedback from sites and members, continues to work on building and refining the district debriefing plan as we become more experienced and better trained. Team members, materials and lists will need to be updated regularly to accommodate the district's changing needs, personnel and assignments. We recognize the need for continued training of our team members and for the baseline training of those who would like to be on the teams and will be needed in the future. We expect and will be appreciative of feedback and suggestions from anyone involved in or affected by the debriefing process.

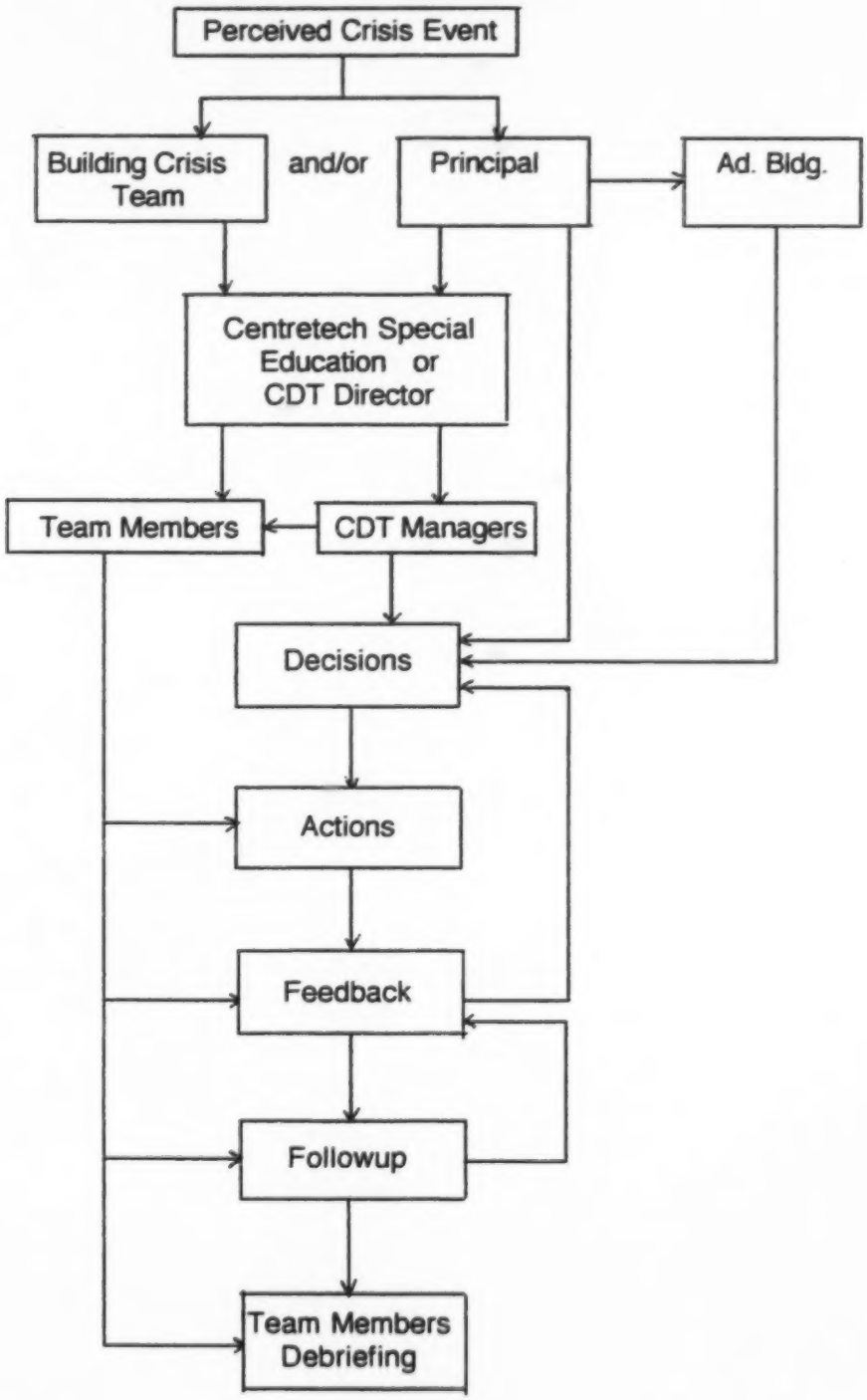
CDT Committee Members

Everett E. McDowell, Director
Dawn Schierling
Kathy Gibbons
Laurie Leek
Carol Mullens
Sharon Calkins
Linda Loyd
Laurie Mullison
Patti Wisner

October, 1995

PROCEDURAL FLOWCHART

CRISIS DEBRIEFING TEAMS PROCEDURAL FLOWCHART



CDT MANAGER'S CHECKLIST

CDT MANAGER'S CHECKLIST

_____Crisis Intake Form information obtained

_____Initial debriefing plan for the site established with principal and building team
- _____ Who will be debriefed
- _____ Where will they be debriefed
- _____ When will they be debriefed
- _____ How many debriefers will be initially needed

_____Centretech Special Education contacted if more debriefers are needed

_____CDT members briefed on the facts of the situation and debriefing plans

_____Provisions to support the debriefings arranged
- _____ Location(s) for members to work
- _____ Access to phones
- _____ Distribution of printed information such as staff lists, class lists, room numbers, building maps, etc.
- _____ Distribution of recording forms (Individuals Receiving Counseling Support) to debriefers

_____Provisions for meals, coffee, tea, etc. arranged

_____Decisions made regarding substitutes for staff involved

_____Decisions made regarding communications with:
- _____ Students
- _____ Staff
- _____ Parents
- _____ Community

_____Decisions made regarding support materials such as:
- _____ Sample letters
- _____ Handouts
- _____ Lists of community resources

_____Decisions made regarding accessing community resources

_____Evaluation of circles of impact
- _____ Particular individuals or groups within the crisis building
- _____ Particular individuals or groups outside the crisis building

(Over)

_____Support for the office staff with guidelines for :
- _____ Information to give callers and walk-ins
- _____ What to tell the media and where to direct them
- _____ Relief from the stress of the front line

_____Decisions made regarding the need for followup support with:
- _____ Students
- _____ Staff
- _____ Parents
- _____ Community
- _____ Anyone not receiving debriefing during the initial day or phase

_____Schedule debriefing for CDT Team members who participated

_____Complete the Debriefing Summary Sheet

_____Collect and send all paperwork and relevant information to the Special Education office at Centretech

_____Make a followup contact with the site, a week after the debriefing, to check on the situation and offer any additional involvement that may be needed.

CDT TEAMS LIST

APS CRISIS DEBRIEFING TEAMS
1995-1996
DEBRIEFING TEAM 1

NAME	POSITION	SCHOOL	SCHEDULE	WORK PHONE	HOME PHONE
- Co-Manager	Psychologist	Arkansas	M-F	755-0323	
- Co-Manager	Counselor	Virginia Court	M-F	366-9594	
- Co-Manager on call	Social Worker	Central	M-F	340-1600	
	School Nurse	Mrachek	M-F	750-2836	
	Psychologist	Jewell Jamaica	T-TH F	751-8862 364-8126	
	Counselor	Kenton Lansing 6th Avenue	M&TH T&F W	364-0947 364-8297 366-6019	
	Affective Education	Montview	M-F	364-8549	
	Psychologist	Columbia	M-F	690-6570	
	Social Worker	Preschools	M-F	207-6286 - page	
	Counselor	East	M-F	340-0660	
(alternate)	Psychologist	Child Find	M-F	363-0484	

DEBRIEFING TEAM 2

NAME	POSITION	SCHOOL	SCHEDULE	WORK PHONE	HOME PHONE
- Co-Manager	Social Worker	Sixth Avenue Tollgate	T,TH,F M,W	366-6019 696-0944	
- Co-Manger	Social Worker	Mrachek	M-F	750-2836	
	Paraprofessional	Rangeview	M-F, mornings	695-6848, mornings 361-2990, afternoons 553-0102 - page	
	Psychologist	Side Creek, green	W&F	755-1785	
	Psychologist	Vassar	W,TH,F	752-3772	
	Counselor	East	M-F	340-0660	
	Counselor	Central	M-F	340-1600	
	Counselor	Century Dartmouth	M,Tam,TH Tpm,W,F	745-4424 690-1155	
	Counselor	Aurora Hills	M-F	341-7450	
	Counselor	Gateway	M-F	755-7160	
	Nurse	Hinkley	M-F	340-1500, ext 7246	

Centretech Department of Student Services/Special Education Phone Number: 340-0510

CDT Director: Everett E. McDowell Work number: 364-8549
Home number:

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DEBRIEFING TEAM 3

NAME	POSITION	SCHOOL	SCHEDULE	WORK PHONE	HOME PHONE
- Co-Manager	Psychologist	Montview	M-F	364-8549	
- Co-Manger	Psychologist	Yale Mrachek	M,T,TH W,F	751-7470 750-2836	
	Counselor	Tollgate Iowa	M,W,Fa.m. T,TH,Fp.m.	696-0944 751-3660	
	Nurse	Centretech	M-F	251-4765 - page	
	Counselor	Gateway	M-F	755-7160	
	Psychologist	Crawford	M-F	340-3290	
	Nurse	East	M-F	340-0660	
	Counselor	Columbia	M-F	690-6570	
	Social Worker	Dartmouth Century	M,T,W M,TH,F	690-1155 745-4424	
	Counselor	South	M-F	364-7623	
(alternate)	Nurse	Child Find	M-F	363-0484	

DEBRIEFING TEAM 4

NAME	POSITION	SCHOOL	SCHEDULE	WORK PHONE	HOME PHONE
Co-Manager	Psychologist	Aurora Hills William Smith	M,W,F T,TH	341-7450 364-8715	
- Co-Manager	Social Worker	Rangeview	M-F	695-6848	
	Psychologist	Iowa Park Lane	M,Wam,TH T,Wpm,F	751-3660 343-8313	
	Counselor	Park Lane Laredo	M,W,Fa.m. T,TH,Fp.m.	343-8313 366-0314	
	Counselor	Vassar	M,T,TH	752-3772	
	Counselor	Jewell Wheeling	T,TH,Fpm M,W,Fa.m.	751-8862 344-8670	
	Nurse	Centretech	M-F	251-2613 - page	
	Social Worker	Virginia Court Vaughn	M,W,THp.m .,F T,THa.m.	366-9594 366-8430	
	Counselor	Yale	M-TH	751-7470	
	Academic Advisor	TH Pickens	M-F	344-4910	
(alternate)	Social Worker	Vaughn	Tpm, W,TH	366-8430 397-0757 - page	

Centretech Department of Student Services/Special Education Phone Number: 340-0510

CDT Director: Everett E. McDowell Work number: 364-8549
Home number: 985-9866

IN-BUILDING CRISIS TEAMS LIST

CRISIS INTAKE FORM

CRISIS INTAKE FORM

1. NAME OF CALLER:_____

   DATE:_____ TIME:_____

2. NAME OF VICTIM(S):_____

   _____

3. BRIEF SUMMARY OF CRISIS:_____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

4. LOCATION OF DEBRIEFING:_____

   _____

5. LOCATION COORDINATOR:_____

   PHONE NUMBER:_____

6. WHO WILL BE DEBRIEFED (STUDENTS, TEACHERS, PARENTS, ETC.):_____

   _____

7. SIBLINGS, RELATIVES OR OTHER INDIVIDUALS OR GROUPS THAT NEED

   DEBRIEFING OR SPECIAL ASSISTANCE:_____

   _____

(over)

RESPONSE PLAN

INITIAL CRISIS TEAM TO RESPOND: _____

CO-MANAGER: _____

CO-MANAGER: _____

GENERAL RESPONSE PLAN: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FOLLOW UP PLANS AND RESPONSIBILITIES: _____

_____

_____

_____

_____

_____

_____

_____

GUIDELINES FOR DEBRIEFING

GUIDELINES FOR DEBRIEFINGS

GENERAL FORMAT FOR FORMAL CDT DEBRIEFINGS

1. **Introductory Phase**
   a. Introduction of the CDT team
   b. Give a brief description of the Debriefing process and its purpose.
   c. Establish the ground rules

2. **Fact Phase:** Participants are asked to introduce themselves and to give a description of what they heard, saw, and did during the incident. Each participant is included in turn by completing the circle.

3. **Thought Phase:** At what point did the individual realize this was an unusual situation?
   Question: *When did you realize this was an unusual situation*?
   Question: *What did you think at the time?*

4. **Reaction Phase:** Sharing of the feelings at the scene, now, and in past situations, if possible.
   Question: *What were your reactions (feelings) at the scene or in relation to past situations?*
   Question: *What was the worst part of the incident?*
   Question: *If there was one thing you could have left out of the event, what would it have been?*

5. **Symptom Phase**: Perceived unusual experiences at the time of and/or since the incident. Expression of the individual's stress response syndromes.
   Question: *What symptoms let you know that this was different from other situations*?
   Question: *What was your most intense reaction at the scene?*
   Question: *What were your reactions later?*
   Question: *What 's not going away?*

6. **Teaching Phase**: Team discusses stress response syndrome and normal signs, symptoms, and emotional reactions. Handouts are given now.

7. **Reentry Phase**: Wrap up loose ends, answer additional questions, provide final assurances, establish a plan of action.
   Question: *What was your moment of strength?*
   Question: *What did you feel good about in yourself?*
   Question: *What was positive about your response?*
   Question: *What will be valuable in the future?*

8. **Referrals**: Individuals are referred for additional help at Team members' discretion.

REMEMBER!

The purpose of the debriefing process. "To help you deal with the thoughts and reactions you may be experiencing and to give you information on how you can help yourself deal with these issues."
Debriefings are <u>not</u> a critique of the incident.

Debriefings have 2 main components:

1) **Psychological:** provide a safe, non-evaluative setting for participants to vent their feelings and reactions. <u>Reinforce: Normal people having normal reactions to abnormal situations</u>
2) **Educational:** provide information on the signs and symptoms of the stress response and on appropriate stress response techniques.

Establish the ground rules.

a. Stress confidentiality and define limits. Ask participants to agree on group confidentiality. No discussing of what was said.
b. Establish that all individuals present should be in this group.
c. Reassure that no one has to talk but you would appreciate their names and what they did at the scene.
d. No one can talk for someone else.
e. No one has rank during the debriefing process.
f. The CDT members are not part of an investigative process.
g. Tell the group that breaks will not be taken during the debriefing.
h. Emphasize that participants should not leave the group and then not return.
i. No one may take notes.
j. Turn off pagers and radios.
k. Do not discuss criminal or illegal behavior.

Formal debriefings achieve the following:

1. Provide a mechanism for ventilation of feelings.
2. Provide reassurance that the feelings and reactions expressed are normal and will subside.
3. Advise those who have not been impacted that a reaction may occur later and discuss methods to deal with it.
4. Provide stress education.
5. Reduce the fallacy of "uniqueness".
6. Reduce the fallacy of being "abnormal".
7. Provide positive interaction with a mental health professional.
8. Reinforce or restore group cohesiveness.
9. Screen those who may not be ready for service.
10. Offer referral as appropriate.

Issues that surface at debriefings involve loss of control, personal vulnerability, guilt, anger, frustration, and seeking blame.

Handouts should be provided for <u>all</u> participants and include relevant information on stress symptoms and management techniques.

When working in groups, it is preferable to use two team members: one to facilitate the group and the other to be attuned to individual needs.

HANDOUTS

Aurora Public Schools

Crisis Debriefing Team
Centretech
(303) 340-0510

CRITICAL INCIDENT STRESS REACTIONS

Over the next month you may experience normal reactions to the kind of experience you've had which may include:

Physical Reactions

- Fatigue
- Insomnia
- Exhaustion
- Over/Under activity
- Susceptibility to illness
- Startle reactions
- Prone to accidents
- Health problems (such as change in appetite, headaches, digestive problems)
- Sleep disturbances
- Nightmares

Cognitive Reactions

- Difficulty with concentration
- Flashbacks
- Isolating
- Need to tell & retell story
- Denial
- Difficulty making decisions
- Memory disturbance/forgetfulness
- Inability to attach importance to anything other than this incident

Emotional Reactions

- Fear
- Guilt
- Emotional numbing
- Amnesia for the event
- Over sensitivity/vulnerability
- Crying at unexpected times
- Reliving past death/trauma experiences
- Anxiety
- Depression/sadness
- Feelings of helplessness/loneliness
- Anger - which may be manifest by scapegoating, irritability, frustration, mood swings, violent fantasies

These are examples of reactions which are normal and, although painful, are part of the normal healing process. There is not a lot anyone can do to make you not experience these uncomfortable feelings but there are some things you can do to feel more whole.

Things to try:

- **Within the first 24 - 48 hours, periods of strenuous physical exercise alternated with relaxation will alleviate some of your physical reactions.**
- **Structure your time - keep busy.**
- **You're normal and having normal reactions - don't label yourself crazy.**
- **Talk to people - talk is the most healing medicine.**
- **Beware of numbing the pain with drugs or alcohol. You don't need to complicate this with a substance abuse problem.**
- **Reach out - people do care.**
- **Keep your lives as normal as possible- keep routines.**
- **Spend time with others.**
- **Help those around you as much as possible by sharing feelings and checking out how they are doing.**
- **Give yourself permission to feel rotten.**
- **Keep a journal - write your way through those sleepless hours.**
- **Do things that feel good to you.**
- **Realize that those around you are under stress.**
- **Accept offered help and ask for needed help.**
- **Eat nutritious, well balanced meals high in carbohydrates and low in sugar.**
- **Avoid excessive use of caffeine.**
- **Don't make any big life changes.**

HANDOUT 1 2/95

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CHILDREN'S RESPONSE TO TRAUMA

Children's responses to trauma vary according to the age of the child. Generally, children respond by reverting to behavior typical of an earlier developmental stage. These responses are considered **NORMAL** if they are of brief (under three weeks) duration. If any of these symptoms continue, there are professionals available to help you with your questions.

AGES 1 - 6	AGES 7 - 11	AGES 12 - 18
Bedwetting	Betwetting	Withdrawal and isolation
Crying	Nightmares	Headaches
Immobility	Change in sleep patterns	Stomach pains
Excessive clinging	- unwillingness to fall asleep	Running away
Thumbsucking	- need for night light	Depression and sadness
Wetting pants	- fear of sleeping alone	Suicidal thoughts *
Loss of bowel control	- fear of darkness	Stealing
Fear of darkness	Irrational fears	Change in sleep patterns
Inattentiveness	Irritability	Sleeplessness
Fear of animals	Disobedience	School problems
Fear of being left alone	Excessive clinging	Nightmares
Fear of crowds	Headaches	Increased sleep
Overactivity	Stomach aches	Confusion
Underactivity	Visual or hearing problems	Violent fantasies
Nightmares	Refusal to go to school	Avoiding talking of event
Inability to sleep without a light or someone else	Poor performance	Delinquent behavior
Awakening during night	Fighting	Use of drugs
Sensitivity to noises	Loss of interest	Use of alcohol
Irritability	Loss of concentration	Sexual acting out
Confusion	Distractibility	Accident prone *
Speech difficulties	Withdrawal	Relationship difficulties
Eating problems	Refusal to talk about event	Change in appetite
Stomach aches	Accident prone *	Aggressiveness
Accident prone *	Appetite disturbances	Risk taking behavior *
Violent fantasies/play	Over/Underactivity	Overactivity
Re-enacting event	Inattentiveness	Underactivity
Wanting to die *	Wanting to die *	Irritability
Wishing to go to heaven *		Confusion
		Inattentiveness

* Any suicidal talk or actions should be taken seriously and professional held should be sought immediately. Younger children do not understand the permanence of death, so do not understand the consequences of "suicidal" behavior. Even very young children can become suicidal.

HANDOUT 2 2/95
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Crisis Debriefing Team
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COPING WITH CHILDREN'S REACTIONS TO TRAUMA

Although children have many of the same reactions as adults do to trauma, they have different ways of expressing their reaction and need some special help to cope. The following are some suggestions for dealing with the child in crisis.

- When disaster hits a family, the child often has to deal not only with the disaster itself, but with the unavailability of his parents who are, themselves, consumed with the disaster. One of the child's biggest fears is the loss or unavailability of his parents when he needs them. This fear often becomes fact in a disaster.
- Your child's fears are real to him. He is truly afraid. He's not trying to make life difficult for you. Treat all fears as genuine.
- Your child needs a lot of reassurance that you will take care of him.
- Keep all promises you make to your child during the crisis. In other words, do not make promises you cannot keep. It is important that he can count on you when all else is in chaos.
- Listen to your child. Listen to his fears. Listen to how he feels. Listen to his explanation about what he thinks happened.
- Explain the facts that you know about the disaster. You may have to explain more than once.
- Encourage him to talk.
- Include him in the clean up activities or other activities designed to return life to normal. He'll feel more in control if he can help.
- Maintain your routine as much as possible.
- Young children need to be held.
- You may need to be flexible with bedtime routines. A child may need for you to stay with him while he falls asleep, he may want a night light, or to sleep with a sibling or with you. If you allow him to sleep with you, you should agree on a time (not more than 3 - 4 days) when he will return to his own bed.
- If your child is fearful of going to school, insist that he go, but accompany him to school. Let teachers and school counselors know when your child is in crisis, they can frequently help.
- Your child may draw pictures of the disaster or re-enact the disaster in his play. This can be very disturbing to adults. Children do not have the verbal skills that adults do, so this is their way of "talking" about the event. They should be encouraged to draw and re-enact the event. Help them verbalize what they are doing, how they feel about it, and what they think happened in the disaster.
- Sharing your feelings about the disaster with your child can be helpful. Telling your child that you were frightened too may help him feel better about his own responses. However, it is best not to share your fears about your (or his) ability to cope. Confidence that both of you will be able to cope is important.
- Do not expect your child to take care of <u>your</u> fears. For instance, do not keep your child home from school or have him sleep with you because <u>you</u> are afraid to be separated from him. Find help for yourself to cope with your own fears.
- Try to find a special time each day to spend together as a family. This is always a good idea, but especially important in times of crisis.
- Do not tell a child a deceased person is "happy in heaven with God or Jesus." Children do not have the concepts to understand this and, all too often, want to join the person in heaven by dying themselves. This can lead to suicidal behavior such as walking in front of cards.
- Have some fun together.

HANDOUT 3 2/95

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MYTHS AND FACTS ABOUT SUICIDE

MYTH: People who talk about suicide don't commit suicide.
FACT: Most people who commit suicide have given clues of some type to one or more people. It is not safe to assume that someone talking about suicide will not attempt it; the majority of those who attempt suicide have stated their intent to someone.

MYTH: Suicide happens without warning.
FACT: While explicit verbal warnings are not always given, there are clues ahead of time. The difficulty is that not everyone recognizes the signs and symptoms that would alert him/her to the possibility of suicide.

MYTH: Suicidal people are fully intent on dying.
FACT: Rather than specifically wanting to die, students who attempt/commit suicide often do so simply because they have exhausted their coping skills and see no other options for relief from pain.

MYTH: Once suicidal, a person is suicidal forever.
FACT: Preoccupation with suicidal thoughts is usually time-limited. Most young people who work through a suicidal crisis can go on to lead healthy lives.

MYTH: Once a person attempts suicide, the humiliation and pain will prevent future attempts.
FACT: Eighty percent of persons who commit suicide have made at least one prior attempt (Hafen & Frandsen, 1986). It is critical that concerned adults and peers monitor a student who has attempted suicide for several months following the attempt. Those students who receive help for their suicidal risk before they have made an attempt have a better prognosis than those who were intervened upon following an attempted suicide.

MYTH: Suicide occurs more often among the wealthy.
FACT: Suicide knows no socioeconomic boundaries.

MYTH: Suicidal behavior is inherited.
FACT: As with other patterns of behavior, suicide sometimes seems to run in families. However, suicide is not a genetic trait, so it is not inherited. What can appear to be a family trait of suicide may be because family members share a common emotional environment and often adopt similar methods of coping. In a family where someone has committed suicide, suicide may be viewed as acceptable in times of distress.

MYTH: People who attempt or commit suicide are mentally ill/psychotic.
FACT: Many suicidal persons historically have had difficulty in working through problems. Other people who attempt or commit suicide choose it as an option when their previously successful means of coping are not effective, and they are unable to otherwise stop the pain they are experiencing. A history of mental illness does increase the risk of suicide.

MYTH: Talking about suicide can encourage a person to attempt it.
FACT: On the contrary, initiating a discussion of suicidal feelings may give a suicidal adolescent permission to talk about the pain she/he is experiencing and, by so doing, provide significant relief. It is highly unlikely that discussing suicide would influence a nonsuicidal person to become preoccupied with the idea.

MYTH: People who attempt suicide just want attention.

FACT: Suicide should be considered a "cry for help." Persons overwhelmed by pain may be unable to let others know they need help, and suicide may seem the best way to relieve the pain. Suicidal behavior may be a desperate move to reach out for much needed help.

MYTH: Suicide is most likely to occur at night as well as over the holiday season.

FACT: Suicides can occur at any time, regardless of season, time of day or night, weather, or holidays. Childhood and adolescent suicides, however, are most likely to occur in the spring, and second most likely to occur in the fall. Most childhood and adolescent suicides occur at home on weekends or between the hours of 3 p.m. and midnight (Eyeman, 1987; Indiana State Board of Health, 1985).

MYTH: When depression lifts, there is no longer any danger of suicide.

FACT: This is a dangerous misconception. The lifting of depression often accompanies the development of a suicide plan and the final decision to commit suicide. If the improvement in mood is sudden and circumstances have not changed, the risk of suicide remains high.

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DOs AND DON'Ts RELATED TO SUICIDAL THREATS

The publications of many organizations and governmental agencies contain advice for people who want to help suicidal youngsters. That advice is summarized below.

DOs

LISTEN to what the student is saying and take his/her suicidal threat seriously. Many times a student may be looking for just that assurance.

OBSERVE the student's nonverbal behavior. In children and adolescents, facial expressions, body language, and other concrete signs often are more telling than what the student says.

ASK whether the student is really thinking about suicide. If the answer is "yes", ask how she/he plans to do it and what steps have already been taken. This will convince the student of your attention and let you know how serious the threat is.

GET HELP by contacting an appropriate CRT member. Never attempt to handle a potential suicide by yourself.

STAY with the student. Take the student to a CRT member and stay with that student for awhile. The student has placed trust in you, so you must help transfer that trust to the other person.

DON'Ts

DON'T leave the student alone for even a minute.

DON'T act shocked or be sworn to secrecy.

DON'T underestimate or brush aside a suicide threat ("You won't really do it; you're not the type"), or try to shock or challenge the student ("Go ahead. Do it."). The student may already feel rejected and unnoticed, and you should not add to that burden.

DON'T let the student convince you that the crisis is over. The most dangerous time is precisely when the person seems to be feeling better. Sometimes, after a suicide method has been selected, the student may appear happy and relaxed. You should, therefore, stay involved until you get help.

DON'T take too much upon yourself. Your responsibility to the student in a crisis is limited to listening, being supportive, and getting her/him to a trained professional. Under no circumstances should you attempt to counsel the student.

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GUIDELINES FOR RESPONDING TO A STUDENT'S DEATH

1. React to the student's death. Share your reactions with the class.

2. Let the students talk and write about their feelings.

3. Listen to what students have to say. It is important not to shut off discussion.

4. If the student died of an illness and it is appropriate to do so, discuss the illness. This is especially useful for younger children who may need to separate the illness of the child who died from any medical problems his or her classmates experience.

5. Never tell young children, "God took Sally away because He loves her," because children will wonder if it's a good idea to be loved by God. Likewise, don't say, "Sally went to sleep." You may create a class of children afraid to go to sleep.

6. A "regular" day may be too hard for grieving students. Offer choices of activities, such as letters, journals, and discussions.

7. If the students want to, let them write sympathy notes to the parents or to a student who has suffered a loss. Provide an address or offer to deliver them.

8. If acceptable to the affected family, make sure that funeral times are well publicized, perhaps including ideas on funeral etiquette.

9. If applicable, share any cultural information related to the meaning of death and death observances that will help students understand and respond comfortably to affected family members.

10. Talk with students about their concerns regarding "what to say" to other bereaved students and the family of the deceased. Emphasize that trying to avoid grieving individuals or being overly solicitous to them will not help. Students should be themselves and share their caring feelings and support. Point out the need to resume normal relationships.

11. Remember that your class may remain quiet and depressed for some time after the death (perhaps even a month), and that some students may begin to act out noisily and physically as a method of dealing with their feelings.

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HOW PARENTS CAN HELP

- Much of the recovery work involving a crisis can best be facilitated by parents.
- The school may meet with parents in small groups and provide information as to what to look for and how they can help their children.
- Some parents may need individual help before they are ready to help their children.
- The school may provide opportunities for parents to discuss, in groups, their own responses and worries.

Crisis and Children

When people experience a crisis, family routines often are disrupted, and parents often face additional tasks and demands on their time. A crisis can effect the members of a family or of an entire community. Often it is hard for young children to understand what has happened during times of crisis. Some children may have completely confused views of the situation and may need your continued guidance and understanding through the experience. How you help your own children work through their difficult times may have a lasting effect.

Children can experience the same intense feelings that adults feel about a crisis. This is a normal reaction. Some children may show their feelings in a direct and immediate fashion, while others will wait until a later time. Most children will be confused by any sudden interruptions to their routines. Crisis situations are difficult for both children and adults.

Each child in a family may react differently to crisis. Following a crisis, some children may:

- Become more active and restless;
- Worry where they will live, and what will happen to them if homes have been damaged;
- Become upset easily - crying and whining;
- Become withdrawn or depressed; and/or
- Feel afraid at night or when alone.

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FAMILY GRIEF

Parents would like to protect their children from the hard facts of life, but they cannot. When a family death occurs, the children are affected and may react in different ways depending upon their age and experience. Adults should remember the following points:

- Children need to be allowed to respond to the death of a family member in their own way. Each family member's relationship with the deceased is unique, and their response to the loss may vary from one person to another. Children must be allowed to respond in a way that is right for them even if they act as though nothing is wrong following a death.

- It is important not to exclude the children when grieving. Parents need to talk about their sadness with their children. Often children will blame themselves for their parents' sadness if the subject is not discussed openly. Very young children <u>especially</u> will view adults' anger, frustration, or sadness as being something for which they are responsible.

- Young children do not perceive that death is permanent. Children may see death as a bogey-man or as an invader who is coming to get them. Children over age 12 can understand death as adults do. The issue of death may become religious or philosophical, and they may question the justice of God who allowed the death to happen. It is not uncommon for adolescents and teens to have difficulty expressing their emotions regarding death and loss.

- Grief can be a critical problem for children. If a parent sees major changes in a child-such as a change in sleeping and eating habits, a drop in grades, or talk of suicide-within 18 months after a significant death, the family should seek professional counseling.

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HELPING CHILDREN IN YOUR HOME

Long before we realize it, children begin experiencing loss and grief. The child may have moved, his pet may have died, he may have seen death on TV or he may have had an important person in his life die. The child's ability to cope with a loss can be helped by having a significant adult become involved and face the death with him. It is normal and healthy for children to grieve.

To assist a child in facing the death of a significant person in his life, we must be willing to listen to what he thinks, and what he asks. We must sit down with him, hug or touch him and let him know we don't have all the answers to these hard questions. Children of all ages may participate in their loved one's dying in ways which are appropriate. Young children can visit, even if only briefly, talk on the telephone or send a picture. A teenager could mow the lawn, help personal care or write a letter.

HERE IS A LIST OF SUGGESTIONS:

- Reassure the child that the death is NOT a result of negative thoughts, feelings, wishes or actions.
- Notify school personnel of the home situation.
- Offer factual explanations. Answer only the questions the child asks. Use books to help you and the child talk together.
- Talk with the child about previous losses.
- Honestly share your feelings and emotions. It's okay to cry with your children.
- Share memories of the person who is dying/has died.
- Allow kids to be kids, to play and be with their friends and continue usual interests and activities as they desire. Don't forget physical needs like food and sleep.
- Be sensitive to the fact that children sometimes are not able to talk about their feelings. Maybe they can express them through art, music, puppets, poetry or writing.
- Offer children the choice to attend and participate in whatever services or rituals commemorate the life of the one they loved. Help them to know what to expect. For younger children you may wish to have a trusted adult available to them.
- Allow children to be themselves and to express their grief in their own way. It may even seem to you they are not grieving at all.

WHAT CHILDREN'S GRIEF MAY LOOK LIKE:

- Physical Sensations - Stomach pains, chest tightness, headaches, etc. Help the child understand these are normal and temporary in grief.
- Feelings - Fears and worries about being left; about themselves or other people dying; open anger and hostility; guilt. Talking children out of their feelings may not be helpful. Sometimes these feelings may be hard to bear. If you are unable to listen can someone else?
- Behaviors - Not getting along with friends; difficulties at school; taking on a "sick role", nightmares. Realize this may be normal and try not to over-react. If behavior is prolonged, consult professionals such as school personnel or other mental health professionals.

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SAMPLE LETTERS

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SAMPLE STATEMENT FOR INITIAL ANNOUNCEMENT OF CRISIS EVENT

TO:

FROM:

"We have just been advised of a tragedy involving a member(s) of our school. I am sad to announce that _____ has died/has been in a serious accident. As soon as we have more information, we will pass it on to you. People will be available in the building to help those of you who need extra support in dealing with this situation. Your teachers will advise you of the location and times available for this support.

"As soon as we know the family's/families' wishes regarding _____, we will share that information with you. We ask that all students remain in their classrooms and adhere to their regular schedules."

COMMUNITY RESOURCE LIST

Community Resources

Aurora Public Schools

ANY EMERGENCY

Aurora Police Department	911
Victims Assistance, Adams County	659-7735
Victims Assistance, Arapahoe County	643-4500
National Child Abuse	1-800-422-4453
United Way Helpline	433-8900

DRUGS AND ALCOHOL

Alanon/Alateen	321-8788
Alcoholics Anonymous	322-4440
Narcotics Anonymous	832-3784

FAMILY CRISIS

Adams County Social Services	287-8831
Arapahoe County Social Services	795-4850
Comitis Crisis Center	343-9890
Child Abuse	795-4825
Crawford Family Resource Center	340-0880
Gateway Battered Women's Shelter	343-1851
Human Services, Inc.	368-8901
Hospice of Metro Denver	778-1010
Families First	745-0327
Alternatives to Family Violence	289-4441
Southeast Aurora Family Resource Center	671-9088

RUNAWAY

National Runaway Hotline	1-800-231-6946

RAPE

Rape Assistance Hotline	322-7273
En Español	329-0031

SUICIDE

Comitis Crisis Center	343-9890
Bethesda Support Line	869-1999
Aurora Mental Health	693-9500

EMERGENCY FOOD AND CLOTHING

Aurora Inter Church Task Force	360-0260
Salvation Army	295-3366
Iola Family Assistance Center	363-9543
Share Colorado	428-0400
Food Stamp Office, Adams County	363-4200
Food Stamp Office, Arapahoe County	695-1810

ADDITIONAL ASSISTANCE

Homework Hotline	322-Pass
Victims Services	341-8487
Ask-A-Nurse	777-6877
Aids Hotline	1-800-342-AIDS
Tri County Health (Immunizations/Medicaid Assistance)	341-9370
MDPN Clinic	343-6130
Rocky Mountain Poison Control	629-1123
Kids In Need of Dentistry	761-1340
Aurora Educators for Diversity	366-1456
Parents and Friends of Lesbians and Gays	333-0286

STUDENTS RECEIVING COUNSELING SHEET

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Students Receiving Counseling Support

School _____ Administrator _____

Date	Name	Grade	Who Saw Child	Follow-up Needed Y or N	Comment

DEBRIEFING SUMMARY SHEET

DEBRIEFING SUMMARY SHEET

Date:

Location:

Teams Involved:

Manager(s) Name(s):

Brief Summary of the Debriefing. Give a brief description of the events and actions with notes of strong points, any problems encountered, and recommendations for improving the process.

PLAIN PAPER FOR NOTES